Office of Inspector General

Illinois Department of Public Aid

2002 Annual Report

George H. Ryan
Governor

Robb Miller
Inspector General

December 2002

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December 30, 2002

To the Honorable George H. Ryan, Governor, and Members of the General Assembly:

I am pleased to present you with the Office of Inspector General's Annual Report for Calendar Year 2002. This report details activities that have enhanced the integrity of the Illinois Medical Assistance Program and other programs of the Departments of Public Aid and Human Services. This Office has become a national leader in program integrity through the collective efforts of nearly three hundred staff around the state as well as the commitment and dedication of IDPA and IDHS.

This Office has achieved national recognition by maintaining a clear focus on our mission and through successful collaborations with both Departments. We have improved the fiscal integrity of those agencies and increased the safety of their employees and the physical security of our facilities.

This will be my final report to you as I am retiring on December 31, 2002. For the last 11 years, it has been my honor to lead these activities committed to combating fraud and abuse at every level. I hope this report contributes to the continued support the OIG must have to carry out its mission to prevent, detect and eliminate fraud, waste and abuse.

Sincerely,

Robb Miller, CFE
Inspector General

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BACKGROUND

The General Assembly created the Office of Inspector General (OIG) in 1994 as an independent watchdog within the Department of Public Aid (DPA). The position of Inspector General is appointed by and reports to the Governor and requires confirmation by the State Senate. The OIG operates within DPA but does so independently of the agency director.

Prior to 1994, the Division of Program Integrity (DPI) was responsible for many of the duties absorbed by the OIG. The most significant difference between the two entities lies in the OIG's statutory mandate "to prevent, detect and eliminate fraud, waste, abuse, mismanagement and misconduct." This directive to first prevent fraud has enabled the OIG to increase its impact on DPA's programs. Nonetheless, DPI built a solid foundation from which the OIG could carry out its mission.

Scope

The OIG investigates misconduct in programs administered by DPA and DPA legacy programs in the Department of Human Services (DHS). Since the creation of the OIG, DPA directors and DHS secretaries have routinely recognized the OIG's independence while jointly promoting program integrity and assuring access to financial and medical assistance for persons in need.

Acknowledging its mandate, the OIG has developed and enhanced a broad range of tools and techniques to do surveillance, promote prevention and fight fraud and abuse in Medicaid, KidCare, food stamps, cash assistance and child care. The OIG also has enforced the policies of DPA, DHS and the state of Illinois affecting clients, health care providers, vendors and employees.

Staffing

During 2002, the OIG had an authorized staffing of 295 employees. They are investigators, accountants, attorneys, nurses, data analysts, quality control reviewers, fraud researchers, information specialists and administrative staff. The OIG recognizes that effective program integrity rests on a foundation of teamwork within DPA and with the many local, state and federal agencies that share the OIG's goals. Years of collaboration have produced the successes for which all the OIG's program integrity partners can rightfully share credit.

Networking

OIG employees have been active in the Association of Inspectors General, a national group supporting the work of IG's at local and state levels, and in the federal Centers for Medicare and Medicaid Services' Medicaid Fraud and Abuse Technical Advisory Group (TAG). The OIG staff also has been active in the National Welfare Fraud Directors Association, United Council on Welfare Fraud, National Health Care Anti-Fraud Association, National Association for Program Information and Performance Measurement, National Internal Affairs Investigators Association and the American Society for Industrial Security.

National Recognition

The program integrity advances realized in 2002 can be traced to the innovative thinking, pioneering efforts and detailed work performed by OIG staff in the preceding years.

DPA and the OIG have received national recognition for deploying numerous integrity efforts deemed "best practices" in the country. The U.S. General Accounting Office (GAO), the auditing arm of Congress, mentioned Illinois extensively in its report entitled *"Strategies to Manage Improper Payments: Learning from Public and Private Sector Organizations,"* issued in October 2001. Illinois was one of only three states profiled for their best practices by the GAO. Illinois received mention for DPA's ground-breaking 1998 Payment Accuracy Review, OIG's data mining efforts, Fraud Prevention Investigations and the OIG's Fraud and Abuse Executive, who coordinates state and federal law enforcement activities involving Medicaid.

The Health Care Financing Administration (predecessor to the Centers for Medicare and Medicaid Services) selected Illinois for the first in the nation program integrity review by that agency. In its final August 2000 report, the federal agency said, "The state agency has taken many pro-active measures necessary not only to identify abusive provider payments, but also to prevent them from occurring in the first place. Especially noteworthy is the weaving of the 'think-tank' mentality with exceptional internal and external interaction among entities dealing with program integrity issues."

Illinois' achievements have attracted the interest of Congress, the GAO, the U.S. Justice Department and the Association of State Medicaid Directors, where the IG and OIG staff have made formal presentations.

The OIG has continued its efforts to prevent and detect fraud and abuse by developing a keener understanding and more tools to raise the standards for program integrity.

And just as important, the dedicated OIG staff reaffirmed that the old-fashioned, get-in-the-trenches work of audits, peer reviews, investigations and quality control reviews continues to pay ever larger dividends in financial recoveries and cost savings. Audit collections alone rose to $18.3 million in Fiscal Year 2002, a nearly 79 percent increase since 1992.

These and other laudable advances detailed in this annual review have, after years of hard work, produced a broad-based platform on which future program integrity efforts can be developed, improved and expanded.

Legislation

In August 2002, Governor Ryan signed PA 92-0789 (SB2225) into law, expanding and strengthening DPA's program integrity mission, particularly regarding non-emergency medical transportation (NET), an area in which earlier OIG studies had detected a high degree of fraud and abuse.

For the first time in Illinois, NET principals now must submit to criminal background checks using their fingerprints. The requirement applies to every shareholder with 5% or more of the outstanding shares of the corporation, every partner in a partnership, a sole proprietor, each officer and manager of a Medical transportation provider. Those who have committed health care and financial crimes will not be allowed

to participate as Medicaid providers.

The law makes enrollment of a NET provider conditional for 180 days. DPA can terminate the provider's Medicaid eligibility without cause during the180 days, and termination would not be subject to a DPA administrative hearing. After 180 days, DPA can terminate NET providers after a reasonable notice and opportunity to respond prior to an evidentiary hearing.

The new law allows DPA to refuse to accept prior and post-approval requests for non-emergency transportation authorizations for a provider if DPA has begun the termination process, begun withholding payments or issued a withholding notification due to reliable evidence of fraud or willful misrepresentation pending investigation. The providers can be required to post a surety bond. DPA has been establishing the criteria and requirements for determining when a surety bond must be posted and the value of the bond.

The new law also provides that if a Medicaid provider has been terminated based on a felony conviction for fraud or a willful misrepresentation involving Medicaid or Medicare, the provider would be barred from Medicaid for five years or for the length of the criminal sentence, whichever is longer. If a Medicaid provider has been terminated, then reinstated and is terminated again, the provider would be barred from participation for at least two years. If the provider has been terminated a second time for a felony conviction involving Medicaid or Medicare, the provider would be barred for life.

Another provision of the new law allows DPA to recover interest on the overpayments at 5% per year if a provider received Medicaid overpayments because it willfully made false statements or misrepresentations involving Medicaid billings and payments. The law also eliminated a rule that DPA can withhold Medicaid payments for no more than 120 days if a final administrative decision has not been issued within that time. DPA has been establishing a process and criteria by which a vendor may request full or partial release of withheld payments.

THE SCIENCE OF FIGHTING FRAUD

The year 2002 saw the full blossoming of the pioneering Fraud Science Team (FST), which uses a variety of technological tools to develop automated fraud detection routines, targeted review efforts, and prevention and detection studies. The team works with DPA to develop ways to fight fraud and abuse before it can evolve and spread. Among similar program integrity operations in the country, the FST may be the only one of its kind and has been cited by the federal reviewers as an innovative fraud detection approach.

FST, along with deployment of the Data Warehouse and the Client Server-Surveillance Utilization Review Subsystem, have advanced the OIG's surveillance, prevention and detection capabilities to make the provider community and the public more aware of the heightened program integrity in the state's social services.

FST works daily with the rest of OIG and DPA to identify vulnerabilities and solutions in DPA's Medicaid payment system. Also, FST contributes to the Medicaid Partnership Initiative, a data-driven enforcement initiative of the U.S. Attorney's Office, Illinois State Police, U.S. Department of Health and Human

Services' (HHS) Office of Inspector General and DPA's OIG.

To fight fraud and abuse in Medicaid, the OIG has increasingly turned to the latest technology, scientific research and sampling techniques. Through FST, the OIG has formulated innovative approaches and tools for more quickly detecting and preventing the fraud and abuse that in earlier times may have gone undetected and unchecked. FST's scrutiny has focused on hospital transfers, inpatient hospital stays, list sharing, random claims sampling, mass mailings and medical transportation.

FST conducts studies of inpatient Diagnostic Review Group (DRG) billings that use a statistically-valid sampling strategy to assess the payoff of a full scale targeted review and collection effort. The OIG uses FST's results in both the inpatient and non-institutional areas to identify fraud referrals, establish desk reviews, target field audits, identify review efforts and establish self-audit reviews. FST also identifies program integrity solutions, including prepayment claims processing system edits, policy modifications and operational changes.

Random Claims Sampling

FST manages the Random Claims Sampling (RCS) project, which measures payment accuracy and identifies previously unknown vulnerabilities in DPA's payment system and areas where increased enforcement and prevention efforts are needed.

RCS was designed to obtain estimates of the overall payment and service accuracy rates over time and rates of key subgroups; help focus enforcement and detection efforts; broaden existing enforcement to increase the likelihood that perpetrators other than those identified through current detection activities face scrutiny; deter the submission of erroneous and fraudulent billings; identify vulnerabilities in Medicaid to help guide OIG's fraud and abuse detection efforts; and provide a database to identify erroneous billings more accurately and more rapidly. This program was implemented in July 2002.

RCS is an outgrowth of the 1998 Payment Accuracy Review, the first of its kind in the nation, which revealed a higher standard of payment accuracy for the Illinois Medicaid program than Medicare and two other states' Medicaid operations. The review revealed that Illinois correctly spent 95.28%, plus or minus 2.31%, of the dollars paid to providers and set the benchmark for future accuracy reviews.

The Illinois Payment Accuracy Review attracted the interest of Congress, the Association of State Medicaid Directors and individual states interested in doing their own payment accuracy studies.

Hospital Transfer

The Hospital Transfer project identifies instances when a hospital has transferred a recipient to another hospital but billed the event as a discharge, not a lower-paying transfer. To focus on those claims with the greatest potential for recovery, FST worked with DPA's Division of Medical Programs and the U.S. Department of Health and Human Services' Office of Inspector General to identify the 240 claims with estimated overpayments exceeding $2,500 during a three year time period. To determine the estimated overpayment on these 240 discharges, DPA's Division of Medical Programs re-computed the hospital claims as if the patients were transferred. Based on this recalculation, there would have been overpayments of $1,718,951 on 229 of these claims by 88 hospitals.

The OIG sent letters to the hospitals requesting they document their claim codes as discharges or make

restitution to the state. The hospitals repaid the overcharges or provided additional documentation to indicate the original discharge code was correct. DPA has provided additional guidance to hospitals on the importance of correctly coding transfers and discharges and to review effective controls in the claims processing system to detect inpatient hospital claims that were improperly coded as discharges.

Through this process, the OIG has recovered more than $1 million and prevented several hundred thousand dollars in future billings. The project's second phase is underway to examine subsequent billings for hospital transfers.

Hospital Inpatient DRG Project

The project identifies specific characteristics that would indicate a DRG was upcoded, then targets the claims meeting that criteria for review and potential recoupment. For the first pilot, FST examined short stay claims for DRG's 386 and 986. FST selected a statistically valid random sample of records where the length of stay less than 7 days. The error rate was estimated to be more than 50%. The universe of all such claims was then identified, and the associated hospitals have been offered the opportunity to self-audit these records. Those hospitals choosing not to participate in the self-audit are instructed to send OIG the records for review. The hospital inpatient DRG project is expected to pay an estimated $2 million to $3 million and prevent $500,000 to $1 million a year in payments.

Time Dependent Billing

One good example of FST's unique work is the Time Dependent Billing Routine. This initiative assigns a minimum time to procedure codes to identify physicians who submit claims for services totaling more than 12 hours a day. FST identified three categories of procedure codes: time dependent, non-time dependent and DPA assigned. From this analysis, FST identified numerous providers who bill for in excess of 24 hours a day.

Time-dependent codes are those for which the Current Procedure Terminology (CPT) book specifies the minimum amount of face-to-face time the provider should spend with the patient. Non-time dependent codes are those for which no time frame is recommended and for which FST assigned an average time of three minutes per service. DPA assigned codes are for those which FST staff and professional consultants have agreed upon an assigned number of minutes that would be necessary to provide the minimum level of care.

Based upon the aggregate analysis, detail reports are created on the identified physicians and their alternate payees. Selected physicians are then referred to the Illinois State Police's Medicaid Fraud Control Unit (MFCU) for investigation, HHS's OIG for audit or to DPA OIG for appropriate action. The Time Dependent Billing Routine has identified $9 million likely overpayments. Administrative actions taken against these providers has resulted in withholds of nearly $1 million and one-year cost savings of nearly $300,000.

List Sharing

List sharing is as much a broad methodology as it is a specific routine. The goal of list sharing is to take the universe of paid claims during a specified period and identify circumstances where the claims indicate

a network of questionable relationships. With list sharing, FST can look at providers of the same type, relationships between primary service providers and ancillary service providers and terminated providers with a large number of recipients in common with active providers. FST can also examine groups of recipients with providers in common.

With this method, FST can identify situations where a group of recipients have used the same group of providers and where a targeted group of recipients, i.e., recipients with a high average mileage per service, have claims in common with providers. Although being used for informational purposes, once researched and tested, list sharing could be used as a fraud detection tool to identify networks of providers and recipients for review.

Mass Mailing
FST developed a program to select possible inappropriate payee relationships from all alternate payees. Upon identification of these inappropriate alternate payees, the related physicians will be sent an information notice advising them of the amount of dollars billed under their provider ID by each alternate payee.

Transportation
FST has developed and deployed two transportation routines during FY02 that are discussed further in the "Focus on Transportation" section of the Annual Report. These are the transportation/hospital inpatient stay and transportation/medical services routines.

TECHNOLOGY KEY TO INTEGRITY

Data Warehouse
Being able to tap into a vast storehouse of information from a personal computer and target the information search have served to sharpen the OIG focus on detection and prevention of fraud and abuse. With DPA's Data Warehouse, OIG staff has quick access to six years of Medicaid data on recipients, providers and payees. The data include the paid and rejected claims submitted by providers, provider and payee enrollment information, recipient eligibility information and a wide range of reference information. The Data Warehouse gives OIG analysts a fast-responding tool to help identify fraud and supports OIG audits, investigations and prosecutions. Results are often available within hours compared to weeks under the previous data retrieval system.

Client Server-Surveillance Utilization Review Subsystem
Implementation of the Client Server-Surveillance Utilization Review Subsystem (CS-SURS) will enhance the OIG's ability to monitor DPA's $8 billion medical assistance program. CS-SURS makes data retrieval speedier and more adaptable for checking utilization of medical services, levels of medical care and quality assurance.

A central piece of DPA's Medicaid Management Information System enhancement, CS-SURS is a personal computer-based system which evaluates aggregated data to identify medical payment patterns

exhibited by providers and recipients. This application software is vital because it produces reports which can lead to the termination, voluntary withdrawal or suspension of providers from Medicaid and to financial recovery.

This software also produces reports which can lead to the restriction of Medicaid recipients to one physician and/or one pharmacy, producing cost avoidance savings.

Case Tracking

CASE (Case Administration and System Enquiry), another piece of the computer enhancement project, will streamline OIG processes, save time and allow for more resources to be devoted to fraud prevention and detection.

The OIG has manually tracked cases under review with an enormous number of paper files. The number of cases – Medicaid and non-Medicaid – handled by the OIG surpasses 15,000 a year. The current system uses 322 standard forms and templates. Several Access databases, along with mainframe databases, WordPerfect documents and Quattro Pro spreadsheets, have been developed to assist in tracking the various OIG projects. The databases, documents and spreadsheets are stand-alone components in dire need of a common system to eliminate the redundancy and provide electronic capabilities necessary to streamline and track all cases through the entire review process.

The challenges of effectively, comprehensively and periodically monitoring all cases with the OIG have mushroomed as the caseloads and the complexities have grown in recent times. Keeping tabs on all elements of each case along every step of the process from start to finish consumes untold manpower and resources. To manage the cases individually and collectively requires the latest technology so that the OIG's limited budget resources can be maximized to prevent and eliminate fraud, waste, abuse and mismanagement in social services.

CASE provides the OIG's staff with the means to centralize maintenance and storage of data used in case reviews. The system will be able to track the progress of each case and link all the information necessary for analysis, correspondence and final action together for electronic transfer from one review process to the next. The intent is to automate the series of manual processes performed in the surveillance and utilization review of Medicaid plus all the investigations conducted by the Bureaus of Investigations and Internal Affairs and the research done by the Administrative Support Unit's Central Verification Unit.

The benefits of CASE are increased productivity, enhanced management, more efficient access to data and greater savings in preventing and eliminating fraud, abuse and waste.

After a competitive bidding process, the contract to design, develop, implement and maintain this system was awarded to MSF&W of Springfield in August 2002, and the work has begun. It is anticipated the system will be operational in 2004.

Sanctioned Provider Website

The OIG has enhanced its website with improvements to the section on sanctioned providers. On November 25, 2002, all medical providers were sent a notice describing the site's features, which include the names of providers and individuals who are currently terminated, suspended, barred, voluntarily

withdrawn or otherwise excluded from participation in the Illinois Medical Assistance Program. All providers have been put on notice of their responsibility to exercise due diligence to ensure that persons they intend to employ or utilize for Medicaid services is eligible to participate in the program.

COLLABORATION GETS RESULTS

Medicaid Fraud Prevention Executive Workgroup

The OIG could not succeed with its program integrity activities without collaborating with DPA, DHS, Illinois State Police, federal and local prosecutors and other federal and state agencies. A perfect example of this cooperation is the work of the Medicaid Fraud Prevention Executive Workgroup (MFPEW), which meets each month to discuss common problems and to develop solutions to ensure Medicaid's integrity. The five-year-old group has representatives from the OIG and DPA's Division of Medical Programs and Bureau of Information Systems.

MFPEW has initiated a study of the Drug Enforcement Administration numbers used by dispensing pharmacies. Under evaluation with the Illinois Department of Public Health are methods to identify prescription drugs dispensed in a nursing home, then returned to the pharmacy for resale.

The OIG has increased its pharmacy audits to gain a better understanding of how the resale operation works. Another recent project initiated by MFPEW identified overpayments to Federally Qualified Health Clinics, Rural Health Clinics and Encounter Rate Clinics and recommended a computer edit to suspend provider claims for a pre-payment review when duplicate payments occur.

Among other MFPEW projects are studies of spiked payments to providers, independent laboratory and radiology billings and edits to prevent Medicaid overpayments, non-emergency medical transportation and methods to study newly-enrolled providers.

Medicaid Integrity Process Review

The Medicaid integrity process within the OIG involves three bureaus and hundreds of steps and processes that must be followed before errant providers can be disciplined and financial recoveries made. Those steps and processes came under intense study by the Medicaid Integrity Process Review team to chart how the system works and to streamline the system to make it more productive by targeting the worst providers for reviews, legal actions and financial recoveries.

One major development of the Medicaid Integrity Review Process has been the implementation of a "just-in-time, just-enough" approach for pinpointing the worst cases for review and avoiding a growing backlog of other cases that would become outdated before they could be reviewed. The approach has evolved to meet the operational needs identified by the Bureau of Medicaid Integrity's audit and peer review staffs and the Bureau of Administrative Litigation. This process also has served to improve communications among the analysts who select the cases and those who do the audits, peer reviews and legal work. Through the improved feedback, the OIG has enhanced its ability to focus provider reviews on areas prone to fraud and abuse.

The process review also led to other improvements, including the recruitment of more physicians with many different specialties to assist the OIG staff in peer review cases and the use of probe audits and random

record reviews to see if full-fledged audits would be productive.

FOCUS ON TRANSPORTATION

Non-Emergency Medical Transportation
Various studies conducted by the OIG have determined that fraud, abuse, and waste have been serious in Medicaid's non-emergency medical transportation system. The 1998 Payment Accuracy Review found that although the Medicaid payment system had a high level of accuracy, the same could not be said of payments for non-emergency medical transportation. The review estimated that 31% of the $37.2 million in annual expenditures for non-emergency transportation were paid inappropriately. Because of this and other findings, the OIG has targeted this area for closer scrutiny and drafted the 2002 law that strengthens DPA and OIG's efforts to monitor and control this aspect of Medicaid service.

New Provider Verification (NPV)
Starting in 2001, the OIG, working with DMP, began pre-enrollment site visits to medical transportation and durable medical equipment providers designated as high risk or lacking licensing or regulation in the state of Illinois. The project's objectives are to confirm a provider's identity and listed business location, a provider's ability to serve Medicaid clients and that a provider understands Medicaid policies for billing and reimbursement.

The OIG's quality control field staff performs the on-site visits during which a questionnaire is administered. The reviewer asks providers about the information submitted on their Medicaid enrollment application and inquires about ownership and licenses. Individuals and providers are screened to ensure none have been previously barred, suspended or terminated from Medicaid or Medicare.

As of November 30, 2002, reviews of 212 transportation enrollment packages were completed. Seven were denied enrollment, eight were returned by DMP after OIG review because the enrollment packages were not complete, one was returned because of the wrong provider type, three providers requested withdrawal, two were returned because the business was not operational, and four providers failed to contact the OIG resulting in a returned application. The remaining 187 were approved for enrollment. Based on average annual NET payments of $40,000, NPV has saved approximately $1,000,000.

Reviews of 122 durable equipment providers were also completed. One was denied enrollment, six providers did not provide state plan services and needed to enroll through DHS, two enrollment applications were returned because the businesses were not operational, two did not respond to requests for site visits, one was returned because the application package was not complete, and one provider withdrew. The other 109 were enrolled.

The New Provider Verification project evolved from pilot studies done in 1998 and 2000 to confirm the existence of newly-enrolled providers and their ability to deliver Medicaid-covered services.

New Provider Monitoring
The project, began in June 2002, monitors newly-enrolled transportation providers for up to 12 months to identify fraud and abuse in their billing patterns. The providers are referred after an on-site visit identifies questionable activity by the provider, e.g., relationships with a current terminated or suspended provider or

a provider in the hearing process. More than 70 providers have been monitored.

Existing Provider Verification (EPV)
The project reviews the enrollment data and services of non-emergency medical transportation providers who were not part of NPV. The goal is to establish the providers' compliance with DPA rules and policies. The analysis of the data collected in this review will generate the following possible outcomes: identification of providers who submit fraudulent transportation claims and recoupment of overpayments, termination of providers who are not in business, correction of enrollment data and validation of computerized routines that indicate fraud. Began in June 2002, the project will involve the review of more than 90 providers.

Transportation/ Hospital Inpatient Stay
The OIG has targeted transportation providers who submit claims for services while the recipient was in the middle of a hospital inpatient stay. Exclusions were made to prevent the selection of transportation services occurring on either the admission or discharge date because these services could potentially be allowable. Detail reports were produced from this analysis and provided to the MFCU for investigation, HHS' OIG for audit and to the OIG's Bureau of Medicaid Integrity for either desk audit or inclusion into the Existing Provider Verification Project. The project has identified $1 million in overpayments and several MFCU referrals.

Transportation/Medical Services
The OIG also has focused on transportation providers who billed extensively for services to recipients on days when there were no corresponding medical services. Exclusions were made to prevent the selection of persons under 18, Medicare recipients and persons receiving dialysis or other treatment for end-stage renal disease. Also, claims submitted for services from pharmacies, long term care facilities, Kid Care application agents, pre-paid providers, ICF/MRs, state-operated facilities and hospices were not considered matching services as DPA policy requires. The identified providers and detailed information about the submitted claims were then referred to MFCU for investigation, HHS' OIG for auditing or OIG's Bureau of Medicaid Integrity for inclusion in the Existing Provider Verification Project.

RISING DRUG EXPENDITURES DRAW ATTENTION

Prescription Drugs
Medicaid expenditures for prescription drugs have risen by nearly 200 percent to $1.35 billion since 1995. DPA and the OIG have marshaled more resources to look at one of Medicaid's fastest growing expenditures to assure that recipients get medically necessary medications while preventing fraud, abuse and waste. MFPEW has focused its efforts on cutting down on refills too soon and limiting daily doses to what recipients actually need. Prescription drugs and the pharmacies that provide the medications have come under further scrutiny in other ways as well.

Modified Audits
These reviews sample 200 prescriptions randomly selected from a pharmacy's paid claims for a six-month period. The review determines if drugs billed were prescribed or if refills were authorized; if the quantity, strength and dosage billed follow the prescription; and if other billing requirements are met. Because the sample selected is insufficient to justify extrapolating the identified overpayments, only the actual overpayment is recouped. If the amount of identified overpayment is large, e.g., more than $1,000, the OIG can expand

the audit.

Expanding the audit consists of selecting a new audit period and a big enough sample to extrapolate the findings. If the modified audit had identified a specific billing problem, e.g., unauthorized refills, the expanded audit would only focus on refills.

During 2002, the OIG conducted 27 modified script audits, identifying $21,682 in overpayments. In addition, the OIG expanded on four audits, with the two completed ones identifying $45,000 in additional overpayments.

Barred Pharmacists

The OIG discovered that 24 pharmacists previously barred from participation in Medicaid for integrity violations were still involved with the program through new employers. A cross match of barred pharmacists was done with the Illinois Department of Employment Security's Automated Wage Verification System to determine the identity of the barred pharmacists' new pharmacy employers. Letters were sent to the pharmacies informing them they were in violation of Medicaid rules for hiring a barred provider and faced termination.

By the end of 2002, 14 barred pharmacists had been removed from positions where they were serving Medicaid clients. Four pharmacists asked to be reinstated and, after appropriate OIG review, and were allowed to continue serving clients. The remaining 10 continue to be investigated.

LONG TERM CARE UNDER SCRUTINY

Asset Discovery

As the elderly population grows, DPA has been taking an aggressive and cost-effective approach to controlling fraud and maintaining the integrity of Medicaid's long term care expenditures. The agency's long term care-asset discovery initiative (LTC-ADI) conducted pre-eligibility investigations on applications taken in DHS' Cook County's Nursing Home Services office and the DuPage County local office. Begun in 1996, LTC-ADI identified applicants for LTC assistance who failed to disclose their assets or who had unallowable asset transfers. The project targeted applications containing suspicious information or meeting error-prone criteria for in-depth financial investigations. The LTC-ADI project provided excellent savings to the state while identifying and eliminating abuse.

Phase I reviewed 184 LTC applications with a discovery of $1,027,507 in undisclosed assets. After the applicable asset exemptions allowable under state policy were applied, the savings totaled $597,099. Those savings came at a total cost of $216,117, culminating in a net savings of $380,982 with a benefit/cost ratio of 2.76:1.

Due to the project's success, DPA initiated a second phase in 1997. Besides identifying applicants' undisclosed income and assets and unallowable asset transfers and conducting a benefit/cost analysis, Phase II included ancillary savings plus analyses of deterrence and error-prone profiling of applications.

The OIG reviewed 603 applications taken at the same two local offices from May 1997 to February 1998. The review discovered $2,238,030 in undisclosed assets with savings of $1,192,538. Additional savings of $2,288,097 were realized by the withdrawal or denial of 29 applications as a direct result of the investigation. The total savings were $3,480,635. The cost for this project totaled $1,046,528, resulting in a net total of $2,434,107 in savings to the state. The benefit/cost ratio was 3.32:1.

As part of Phase III, DPA has released a Request for Proposals (RFP) to procure LTC-ADI investigative services from a private vendor. The vendor will perform up to 1,000 investigations per fiscal year. Based on projections, the investigations would realize an annual net savings of $3.5 million. DPA would also realize undocumented savings by avoiding various recoupment processes and avoid costly errors with the initial long term care application process. The projected date of initial referrals to a vendor is April 1, 2003.

Seven vendors submitted bids for the project and the evaluation team has completed their review of the bids. The Recommendation To Award (RTA) is currently under review.

Death Notification Project

Under DPA policy, the state's nursing facilities must report timely changes in a Medicaid resident's circumstances, such as death, to DHS and DPA. In July 2000, DPA issued an informational notice to long term care providers reminding them of the requirement to fax patient status changes to the Exception Processing Unit within five days of the change and to maintain the fax confirmation sheet as evidence of the submission.

To ensure providers follow the rules, the OIG launched Phase two of the Death Notification Project Phase in August 2001. This project included the same 26 worst offenders. The results of the second review showed several from the original project were not complying with the timely notification requirements.

In dealing with the providers that fell below the 70% timely reporting threshold, the OIG initiated settlement negotiations with the facilities to resolve the findings through Corporate Integrity Agreements (CIA). Of those 14 facilities, one was resolved prior to the CIA and three were issued CIA's only. Ten facilities entered into CIA's and paid interest to DPA on the overpayments caused by late death reporting plus the costs of the investigation.

Another facility came to the OIG's attention during this process and signed a CIA. The facility has paid interest on overpayments and investigation costs.

Under the agreements, the facilities will be required for 36 months to report to the OIG each instance of their failure to timely report a death or discharge through the LTC/EDI system. During that period, if the facility does not achieve a substantial compliance rate for a six-month period, DPA may impose a monetary penalty. For a third failure, DPA may suspend the facility's Medicaid eligibility.

Expanded Nursing Home Audits

The OIG has expanded the number of annual audits done of Medicaid payments to nursing homes, thereby increasing the amount of overpayments that have been identified for collection. During Fiscal Year 2002, the OIG contracted with five CPA firms to conduct 200 post-payment audits and 100 re-audits of nursing homes receiving Medicaid funding. The private firms identified overpayments totaling $23.4 million. Seventy-eight audits have been closed, and the OIG has recovered $2.3 million so far. In the previous fiscal

year, the CPAs had conducted 130 audits, identifying overpayments of $17.8 million. So far, the OIG has recovered $8.8 million of the overpayments.

Corporate Integrity Agreements (CIA)
During 2002, the OIG entered into settlement and corporate integrity agreements with a large consulting pharmacy, several long term care facilities as part of the Long Term Care Death Notification Project II (DNP II) and with part owners of both long term care facilities and a long term care management company.

A corporation that owns and operates a substantial number of long term care facilities also owned and operated a consulting pharmacy that supplied the corporation's long term care facilities pharmaceutical needs. Department regulations require prescriptions supplied to long term care facilities to be packaged in unit dose allowing for the return and reuse of the drugs. The pharmacy has the choice of destroying or reusing the drug, but if reused, the department must be credited for the value of the reused drugs. In this case, the pharmacy manager reused the drugs but did not credit the department. The pharmacy manager was convicted of fraud. In lieu of sanctioning the pharmacy, which would have resulted in the sanctioning of the long term care facilities due to the same ownership, the pharmacy entered into a corporate integrity agreement requiring outside independent audits annually for five years, annual reporting to the department of these audits, compliance training, etc.

In the DNP II project, 12 long term care facilities that were cited in the first project were found to still not comply with requirements for reporting deaths in the facility within certain time standards, often resulting in overpayments. These facilities entered into corporate integrity agreements with the department whereby should they fail to timely report, the department may levy escalating fines and upon a third occurrence suspend the facility.

In another case, the owners of a long term care management company, who also owned greater than 5% in several long term care facilities were convicted of wire fraud involving Medicare payments. They cooperated with the federal prosecution of others and were not the main parties to the fraud. To avoid the sanctioning of numerous affiliated long term care facilities they entered into a settlement and corporate integrity agreement whereby they have transferred their interests in both the management company and the facilities into a trust and cannot have any management powers over the trusts or the trust assets, must file annual reports and affidavits.

QUALITY CONTROL BROADENS ITS DUTIES

Quality Control's Focus
DPA's quality control reviewers traditionally visited clients in the field to confirm their home addresses and family compositions and determine if working adults resided in the home. Today's quality control reviewers have added responsibilities that contribute greatly to furthering program integrity. Reviewers visit new Medicaid providers to confirm their addresses and abilities to offer services to Medicaid clients, survey Medicaid clients on their satisfaction with their health care and do program reviews among other duties.

While checking for any lapses within the Medicaid billing and health care delivery system, the quality control reviewers help to emphasize the OIG's vigilance and the importance that all providers and recipients adhere

to program integrity with DPA and DHS.

The ongoing special quality control review projects include: New Provider Verification, Random Claims Sampling, Existing Provider Verification, Pharmacy Services Verification and Spiked Payments, all of which have been mentioned previously in this report. Other projects are: Negative TANF/Medicaid case action reviews, Medicaid Client Satisfaction Survey, Medicaid Eligibility Quality Control, School-Based Health Services and the KidCare Program Integrity Plan.

School-Based Health Services

Since 1989, the federal Individuals with Disabilities Education Act (IDEA) and its subsequent amendments have mandated that free, appropriate public education in the least restrictive environment for children with disabilities be provided through special education and related services, such as medical services. The services are defined in a child's Individualized Education Program (IEP). The School-Based Health Services program covers children aged 3-21.

If the child is eligible for Medicaid, DPA claims federal matching funds for both direct services through the fee-for-service program and for the administrative costs. Before July 2001, the Illinois State Board of Education handled the claims submission to DPA from the local education agencies (LEA). As of July 2001, LEAs or their billing agents have submitted their claims directly to DPA. The OIG developed a review protocol for the fee-for-service program.

Effective January 2002, 92.4% of the LEAs have representation by billing agents for the fee-for-service portion of the claims. OIG conducted a technical assistance pilot review on nine schools, one school per billing agent, during the year.

Case documentation and other record-keeping errors as well as claiming payments for services on days schools were not even in session are examples of some of the errors identified in the reviews. DPA and OIG staffs have met with schools, billing agents and educational associations to express the need to increase the integrity of the school-based health services programs.

KidCare Program Integrity Plan

Since December 2001, quality control reviewers examine 55 KidCare cases per month. The plan measures DPA's performance administering KidCare and gathers enrollees' opinions as a way of improving the program and increasing enrollment. KidCare extends health care to children whose family incomes are higher than those who qualify for Medicaid.

The monthly reviews determine if children are eligible for KidCare, if enrollees accurately report eligibility information to DPA and if families have been charged correctly for the KidCare Premium program. The reviews also measure the accuracy of payments to KidCare application agents, assess if DHS/DPA correctly denies applications or cancels children from KidCare, ascertain enrollees' satisfaction with KidCare and detect any unacceptable practices by KidCare application agents.

In addition to the KidCare Program Integrity Plan, a special study was completed reviewing assets and income of KidCare households. The information was collected for 210 cases in conjunction with the regular KidCare Program Integrity reviews. The study began in June 2002, with reviews completed in September 2002. A final report was issued November 2002. The findings revealed asset holdings and annual income

of KidCare households. The report was sent to Governor Ryan and the four legislative leaders as well as being posted on the OIG's website.

Medicaid/TANF Reviews
The federal government had concerns that welfare clients have been inappropriately denied Medicaid as a side effect of moving them off Temporary Assistance for Needy Families (TANF). The OIG initiated a review of negative case actions for Medicaid clients who received TANF to determine the accuracy of those actions by DHS local office staff. A case was in error if there were no valid reasons for the denial, termination, deletion or expiration of medical coverage, or if the termination notice was not sent or not sent timely. An error was also cited if the TANF case was canceled and a medical assistance only case was opened, but a gap occurred in medical coverage.

The error rate for April 2001 to March 2002 was 2.22% or an estimated 1,391 incorrect cases when projected to the universe of 63,099 cases.

Of the 14 actual case errors, four were due to TANF cancellations in which Medicaid cases were canceled or a child deleted because the child turned 18 years old and was not attending school. Three errors occurred when medical cases were established for the persons remaining eligible for Medicaid, but a gap in Medicaid coverage occurred.

Corrective actions by the DHS local offices were completed on all negative case action errors. DPA also issued an action memorandum on November 1, 2002, advising DHS's local offices of the proper procedures to continue medical eligibility when TANF ends.

Medicaid Client Satisfaction Survey
The survey monitors the integrity of Medicaid in Illinois by measuring client satisfaction with medical services. The survey measures quality, access, utilization and fraud through a survey of clients. The OIG originally conducted surveys from April 1996 to March 1999, then resumed the surveys in April 2000 because of DPA's concern with client services. The surveys are administered in conjunction with Medicaid Eligibility Quality Control (MEQC) reviews. Since April 2001, OIG has expanded the surveys to include cases receiving Medicaid and TANF.

Medicaid Eligibility Quality Control (MEQC)
The MEQC provides oversight of the Medicaid eligibility determinations made by DHS local offices. The OIG reviews 600 Medicaid cases a year. Each month, the OIG samples a statistically-reliable number of cases and determines if the cases meet state eligibility requirements. After the eligibility review has been completed, the OIG examines paid Medicaid claims related to each case. Eligibility and payment error rates are computed, and corrective action is initiated to prevent future misspent Medicaid funds. The most recent eligibility and payment rates for federal fiscal year (FFY) 2001 were 14.67% and 2.54%, respectively.

INVESTIGATIONS

Child Care
A child care provider advised the IG and DHS in September 2002 of alleged fraud involving its child care facility in west suburban Chicago. The provider hired a law firm and a consulting firm to conduct an

investigation to determine if staff members submitted false information to qualify about 15 employees for state subsidized child care and if the employees assisted other parents in obtaining state subsidies to which they were not entitled. Allegations also included state payments for child care services on days when children were not in attendance.

In November 2002, the provider reported the allegations were founded and offered $270,209 in restitution to DHS for child care rendered to ineligible applicants and for care not rendered. The IG's Bureaus of Investigation and Internal Affairs reviewed the investigation report and found it thorough and complete. The IG has prepared an agreement with DHS to accept the provider's settlement offer.

Fraud Prevention Investigations

The Fraud Prevention Investigations (FPI) program targets error-prone public assistance applications containing suspicious information or meeting special criteria for pre-eligibility investigations. All 23 Cook County DHS local offices participate in FPI, whose goal is to prevent ineligible persons from receiving welfare benefits, thereby saving tax dollars.

In Fiscal Year 2002, the program generated 4,000 investigations and identified 3,118 cases that led to reduced, denied or canceled benefits. The Bureau of Investigations (BOI) calculated the net savings at more than $9.8 million for all assistance programs, i.e., Temporary Assistance for Needy Families (TANF), Medicaid and food stamps.

Since its inception in Fiscal Year 1996, FPI's estimated total gross savings have reached nearly $45 million. The savings are shared between the DPA (Medicaid 51%) and DHS (TANF/food stamp 49%). In FY2002, FPI saved taxpayers $15.04 for every $1 spent on the program.

Prosecutions

An investigation involving public assistance and child care fraud totaling more than $95,000 was referred to the DuPage County State's Attorney's office for criminal prosecution. The Bureau of Investigations' case was developed with the U.S. Department of Housing and Urban Development (HUD). Investigators found the client failed to report her employment or her self-employment earnings, falsified payroll checks and used multiple identities in various scams, including child care fraud. The alleged overpayment included $14,704 for cash assistance; $24,845 for food stamps and $56,126.25 for child care. HUD also included charges against the client.

An investigation involving public assistance and child care fraud was referred to the Lake County State's Attorney's Office for criminal prosecution. The case involved the client's failure to report her assets and true household income and composition. The prosecution involved a total overpayment of $27,002 for cash assistance, food stamp and child care.

Two investigations involving child care fraud were referred to the Cook County State's Attorney's Office for criminal prosecution. One case involved a client falsifying her payroll information to qualify for child care benefits. The alleged overpayment was $27,203. The case was brought to the attention of BOI by the client's employer. The other case involved the client's falsification of her payroll information to qualify for child care and her failure to report her true earnings. The prosecution package included a child care overpayment of $45,174. This case was developed from a neighborhood newspaper article.

Cross Matches
BOI performed cross matches of databases against recipients of services from DPA and DHS to determine if persons were receiving benefits to which they were not entitled. The cross matches involved employees of the Secretary of State (SOS) and DPA.

The cases identified were matched on criteria that included name, Social Security number and address. When a match occurred, a BOI investigator reviewed the case to determine if earned income had been reported to the DHS local office and if the case had been active in the previous 24 months.

BOI conducted 45 investigations involving SOS employees and determined that eight matches were founded. In four cases, a total of $15,625 in food stamp overpayments had occurred. The cross match involving DPA employees led to investigation of 38 cases. BOI determined that three cases were founded with one of the cases involving $13,508 in food stamp overpayments. The overpayment occurred because the client had failed to report the earned income to the DHS local office so that it could be budgeted for determining the proper level of benefits. Health insurance information from the SOS and DPA was forwarded to DPA's Bureau of Collections, Third Party Liability Section, for possible recovery of medical assistance payments.

BOI notified the SOS' Office of Inspector General so it could take appropriate action in the four employee's cases. DPA, likewise, took appropriate action in three cases that were founded.

Birth Certificate Match
BOI received 37 cases identified through a cross match with the DPA/DHS client database and the Illinois Department of Public Health (DPH). The goal of this cross match was to identify clients who were issued a delayed birth certificate for a child in the assistance unit to determine if the child did exist.

The cases identified were matched on name, date of birth and whether a delayed birth certificate had been issued by the DPH. A BOI supervisor checked each case by name, Social Security number and address in the client database with the cases identified through the cross match. This was done to ensure that the matched cases were accurate and if the public assistance cases had been active during the previous 12 months.

A total of 37 cases were assigned for investigation. In 33 cases, it was determined that the children issued a delayed birth certificate did exist. This was confirmed by the investigators by means of school records, drivers' licenses, hospital records or in-person visits.

In four cases: three had been canceled because the clients could not be located and one had insufficient evidence to prove that the children did or did not exist. During the investigation of this last case, it was learned the client had not been living at the reported address since January 2002. An overpayment of $4,002 from January to October 2002 was identified, and the case has been canceled effective October 2002.

INTERNAL AFFAIRS

Internal Investigations
The Bureau of Internal Affairs has the responsibility to investigate allegations of employee and contractor misconduct. It also oversees the physical security of the agency. In 2002, a number of significant activities

took place. The following describes them with specific examples in some cases.

The Bureau of Internal Affairs investigated allegations of time abuse by nurses having overlapping secondary employment. Five DPA nurses resigned during the investigation, and $5,064 was recovered with voluntary repayment agreements. Involuntary offset proceedings are underway to recoup over $35,000 from several of the former nurse employees.

A KidCare worker was charged with theft over $300 on November 22, 2002. He allegedly defrauded his co-workers and others of more than $6,400. He is accused of falsely claiming his brother died in the September 11, 2001 World Trade Center tragedy. A joint investigation by the OIG and the Illinois State Police revealed there was no such brother. The case worker resigned on the day of his arrest. He is currently out on bond awaiting trial.

A child care contractor employee processed child care benefits for clients and potentially defrauded the DHS program of more than $100,000. BoIA completed an investigation after it was declined by the state police. BoIA referred its evidence to the U.S. Attorney's Office for prosecution.

A Public Aid Investigator falsified his sick leave and resigned. During this investigation, evidence was obtained suggesting the employee of another agency had committed misconduct. This information was referred to the Illinois State Police, and she was charged with misdemeanor theft and felony official misconduct.

A DHS Office Assistant and a civilian accomplice defrauded a ward of the state of $12,000. The case was referred for prosecution but was returned without charges for the department to take administrative action. DHS discharged the employee.

A DPA Office Coordinator abused the Family Medical Leave Act (FMLA) and falsified her time off requests for sick leave to care for a child. An investigation determined that on many occasions, the child was in school and was not being cared for by the employee. She was discharged.

A DHS Office Associate solicited a neighbor to slash the tires of her Local Office Administrator. She pled guilty to solicitation to commit criminal damage to property and resigned.

A DHS Mental Health Technician altered income documentation to receive $250 of increased child care subsidy. She pled guilty to state benefits fraud and was discharged.

A DPA Public Service Administrator was grossly discourteous and intimidating to staff and suspended for 28 days.

A child care subsidy manager failed to report her husband's income or her pay increase in her application for $4,300 child care subsidy. She was terminated by the contractor and indicted for official misconduct and public assistance fraud.

Security and Employee Safety

The Hirsch access control system has been expanded in an ongoing effort to include all existing and new

department facilities. This system utilizes keypads at building entrances for employees to enter pass codes. It also permits some employees to utilize proximity cards for frequent access to controlled areas within buildings. The system tracks and reports employee building access and movement within buildings to controlled areas.

Digital Photo IDs
In May 2002, BoIA completed a three month project to re-credential all DPA employees with new digital photo IDs. About 3,500 badges were issued to employees and contractors using enhancement software and hardware to the Hirsch security system. Since the system stores electronic images, IDs can be easily reissued when necessary, and photos can be printed for security or safety alerts and investigative reasons. The bureau and its security contractors capture the photo images, produce and issue the IDs and maintain the database. The system has been integrated with the system that provides electronic controls over office building access.
Also, BoIA's security coordinator continued to monitor building security guard contracts and performance and assess reported incidents of physical threats against DPA and DHS employees and clients by other employees, clients, non-custodial parents and other civilians.

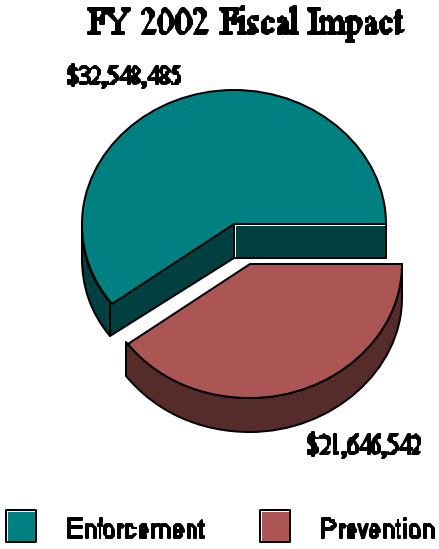
Automatic External Defibrillators
BoIA continued its effort with the department for acquisition and installation of automatic external defibrillators (AED) in the department's office buildings. Also, BoIA's security coordinator compiled a list of employee volunteers with training to operate the equipment and resuscitate stricken employees and visitors. DPA's Bureau of Training has provided the AED training.

Employee Handbook
BoIA management and staff were instrumental in obtaining significant changes and additions to the employee handbook. This activity ended with the release of a more comprehensive handbook, especially concerning work rules and conduct. The handbook rewrite project began several years earlier.

Improper Internet and Computer Usage
DPA established policies governing proper usage of the Internet and computer resources in part at the urging of BoIA. As a result, DPA and OIG began using surveillance and forensics software to identify staff who abuse their computer resources. Several employees or employees of contractors have resigned, been disciplined or discharged during the past year for visiting pornographic sites, sending numerous personal e-mails, extensively surfing the Internet for personal reasons and building a web site for an outside business interest.

FISCAL IMPACT

In Fiscal Year 2002, the OIG had an annual budget of $21.9 million and realized savings of $54.1 million through collections and cost avoidances. The OIG used a range of enforcement and prevention strategies outlined in this report to realize the savings.



Prevention Activities:
Recipient Restrictions
Fraud Prevention Investigations
FS Disqualifications/Cost Avoidance
Medicaid Fraud Prevention Executive Workgroup
Fraud Science Team
Payment Accuracy Review Measurement

Enforcement Activities:
Provider Audits
Client Fraud Investigations
HMO Marketing Misconduct
Provider Sanctions
Medicaid Quality Control Reviews
Food Stamp Disqualifications
Physician Peer Reviews
Internal Investigations
Fraud Science Team

CONCLUSION

In the eight years since its creation, the OIG has moved forward aggressively on numerous fronts to expand the depth and breath of its program integrity mission. By relying on the hard work of OIG staff, the close cooperation with DPA, state and federal agencies, and the deployment of new technology and scientific methods, the standard for program integrity has been raised in Medicaid and other social services. The dividends have been better prevention methods, faster and broader detection tools and increased financial recoveries. Through its efforts, the OIG has succeeded in raising awareness of the importance of program integrity among clients, providers and the citizens of Illinois.

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OIG Published Reports

Title	Date	Description
Fraud Prevention Investigations: FY02 Cost Benefit Analysis	September 2002	Identified $9.8 million in net savings with a benefit of $12.31 for every dollar spent.
Fraud Prevention Investigations: FY01 Cost Benefit Analysis	September 2001	Identified an estimated $8.6 million in annual net savings for 2001, boosting the total estimated savings to $31.4 million since FPI began in 1996.
Child Support Emergency Checks	June 2001	An OIG-initiated study determined that 99.9% percent of the nearly $14 million in emergency child support checks were either legitimate or never cashed. Of the 0.1% of the checks that remain unresolved, four have been confirmed as fraudulent.
Fraud Prevention Investigations: FY00 Cost/Benefit Analysis	November 2000	The program was expanded to all 23 local DHS offices in Cook County. It identified an estimated $8.7 million in net savings, with a benefit of $11.60 for every dollar spent. Since it's inception in 1996, the program's estimated net savings have been nearly $23 million.
Fraud Prevention Investigations: FY99 Cost/Benefit Analysis	March 2000	Identified $4.5 million in annual net savings with a benefit of $12.12 for every dollar spent.
Death Notification Project: Identifying the Cause of Delay in Notification	February 2000	Evaluated whether nursing homes or DHS local offices are responsible for case cancellations due to death. The workgroup found that neither party is completely accountable, and made recommendations for improvement in the notification process. The workgroup also proposed increased monitoring of the 26 nursing home's identified as having the highest incidences of overpayments due to late notice of death.

Title	Date	Description
Non-Emergency Medical Transportation Reviews: Focusing on Compliance	December 1999	A selected group of highly paid non-emergency transportation providers claims were examined to determine the type and magnitude of problems in the program. The study confirmed that problems exist in four primary areas: (1.) record keeping; (2.) prior approvals; (3.) billing for excessive mileage and (4.) billing for non-existent or non-medical transportation.
Project Care: Exploring Methods to Proactively Identify Fraud	December 1999	Targeted assistance cases with multiple children for whom one or more had not received medical assistance. Identified ways by which applicants created fictitious children.
Postmortem Payments for Services other than Long Term Care: Death Notice Delays Cause Overpayments	December 1999	Recommended methods by which non-institutional post mortem payments could be identified more quickly.
Long Term Care Asset Discovery Initiative (LTC-ADI): Pioneering a Proactive Approach for the 21st Century	September 1999	Verified the cost-effectiveness of searching for assets of LTC applicants.
Recipient Services Verification Project: RSVP II-Home Health Care	August 1999	Confirmed receipt by clients of home health care services.
Fraud Prevention Investigations: An Evaluation of Case Selection Criteria and Data Collection Issues	June 1999	Validated the effectiveness of the project's error-prone criteria and processes.

Title	Date	Description
Fraud Prevention Investigations: FY98 Cost/Benefit Analysis	December 1998	Identified an estimated $4 million in net savings with a benefit of $14.25 for every dollar spent.
Maintaining A Safe Workplace: Examining Physical Security in DPA and DHS Offices	October 1998	Examined weaknesses in the security of the agencies and proposes several recommendations for improvement.
Payment Accuracy Review of the Illinois Medical Assistance Program: A Blueprint for Continued Improvement	August 1998	First ever such study in the nation. Identified that the department accurately expends 95.28%, plus or minus 2.31%, of total dollars paid.
Medicaid Client Satisfaction Survey: October 1996-September 1997	July 1998	Measured client satisfaction with quality and access in both fee-for-service and managed care.
Postmortem Medicaid Payments: Identifying Inappropriate Provider Payments on Behalf of Deceased Clients	April 1998	Confirmed that LTC client cases were not being canceled timely resulting in overpayments to nursing homes and made several recommendations for improvement.
Fraud Prevention Investigations: FY97 Cost/Benefit Analysis	February 1998	Identified an estimated $3.63 million in net savings with a benefit of $13.02 for every dollar spent.
Medical Transportation: A Study of Payment and Monitoring Practices	December 1997	Identified policy changes and monitoring strategies.
Funeral and Burial: A Review of Claims Processing Issues	October 1997	Examined policies and procedures of the Department of Human Services in paying for client funeral and burial and made recommendations for improvement.

Title	Date	Description
Maintaining A Safe Workplace: Best Practices in Violence Prevention	June 1997	Identified best practices available to prevent violence and recommended a comprehensive workplace violence strategy to protect employees, clients and visitors.
Medicaid Cost Savings: Commercial Code Review Systems May Prevent Inappropriate and Erroneous Billings	May 1997	Recommended a thorough assessment of software systems for prospective review of billings which have the potential to save the State millions.
Fraud Science Team Development Initiative Proposal	April 1997	Proposed a multi-phase project to develop a prepayment fraud surveillance system for Medicaid claims and a complementary set of innovative post-payment review routines to detect inappropriate payments.
Medicaid Client Satisfaction Survey: April 1996-September 1996	April 1997	Measured client satisfaction with quality and access in both fee-for-services and managed care.
Prior Approval Study	May 1996	Surveyed nine state Medicaid agencies and six private payors to gain an understanding of their drug prior approval systems. Also reviewed prior approval statutes, rules, regulations and literature.
Clozaril Report	February 1996	Studied distribution and payment for the anti-psychotic drug Clozaril and made several recommendations for improvement.
Hospital Inpatient Project Summary Report	April 1994	Found hospitals are underpaid about as frequently as they are overpaid. No evidence was found of hospitals systematically upcoding and unbundling.

Most of these reports are available on our web site at www.state.il.us/agency/oig. They can also be obtained by contacting the Inspector Generals office, Illinois Department of Public Aid at 217-524-7658.

STATISTICAL TABLES

Audits of Medical Providers

The OIG initiates medical audits after computer surveillance of paid claims reveals providers whose billing patterns deviate significantly from group norms or established limits. Medical audits generally cover an 18-month period and are conducted on institutional and non-institutional providers. When a provider is selected for an audit, the provider is contacted, and records are reviewed onsite by the audit staff. Providers with identified overpayments are asked to either repay the liability, present documentation to dispute the findings or request an administrative hearing. Audits are considered completed upon receipt of the provider's payment, a negotiated settlement or the DPA Director's final decision. The provider may repay the department by check or by a credit against billings, in either monthly installments or a single payment. Because providers are allowed to make payments in installments, collections vary, and the amount reported will often cover audits closed in previous quarters. Collections generally result from audits completed in prior periods.

Collection of Overpayments
CY 2002

Audits	564
Collections	$18,436,845.69

Collection of Provider and/or Client Restitutions

Monies collected are from fraud convictions, provider criminal investigations and civil settlements. There is no payback for federal financial participation on restitutions. Restitutions can be paid in one lump sum or by installments and may vary considerably from year to year. The payments depend on when cases are settled and when amounts are ordered to be repaid.

Collection of Provider and/or Client Restitutions
CY 2002

Amount Collected	$946,843.83

Refill Too Soon

The table showing the statistics for the Refill Too Soon program can be accessed at www.state.il.us/agency/oig. The information, required by Public Act 88-554, will be available in early 2003.

Provider Sanctions

The OIG acts as the department's prosecutor in administrative hearings against medical providers. OIG initiates sanctions, including termination or suspension of eligibility, recoupment of overpayments, appeals of recoveries and joint hearings with the Department of Public Health to decertify long term care facilities. Cost savings are based on the total dollars paid to terminated providers during the 12 months prior to termination. Cost avoidance is achieved by refusing to pay any claims submitted by a terminated provider between the initiation of the hearing and the actual termination.

Provider Sanctions
CY 2002

Hearings Initiated	
Termination	47
Suspension	15
Denied Application	20
Recoupment	32
Termination/Recoupment	12
Decertification	18
LTC/Hospital Assessment	20
Child Support Sanctions	105
Total	269
Providers Sanctioned	
Termination	21
Voluntary Withdrawal	11
Suspension	5
Denied Application	11
Recoupment	11
Termination/Recoupment	3
Decertification	2
LTC/Hospital Assessment	20
Child Support Sanctions	64
Negotiated Settlements	21
Other P.A. 88-554 Sanctions	0
Total	169
Cost Savings	$7,393,426.46
Cost Avoidance	$220,124.13

Client Eligibility Investigations

The OIG conducts investigations when clients are suspected of misrepresenting their eligibility for public aid. Investigation results are provided to caseworkers to calculate the overpayments. Cases with large overpayments or aggravated circumstances are prepared for criminal prosecution and presented to a state's attorney or a U.S. attorney. Eligibility factors include earnings, other income, household composition, residence and duplicate benefits. Clients who intentionally violate Food Stamp Program regulations are disqualified for 12 months for the first violation, 24 months for the second violation, permanently for a third violation and 10 years for receiving duplicate assistance.

Client Eligibility Investigations
CY 2002

Investigations Completed	1,440
Estimated Overpayments	
Grant and Food Stamps	$3,029,330
Medical*	$119,130
Types of Allegations	
Employment	17%
Family Composition	25%
Residence	10%
Interstate Benefits	4%
Other Income	7%
Assets	6%
Multiple Grants	0%
Other	31%
Total	100%
Food Stamp Disqualification	1,188

*NOTE: Includes Medical overpayments from Client Eligibility Investigations and Medical Investigations

Child Care Investigations

The OIG conducts investigations when clients or vendors are suspected of misrepresentations concerning child care. Client fraud occurs when earnings from providing child care are not reported, when child care needs are misrepresented or when a client steals the child care payment. Vendor fraud occurs when claims are made for care not provided or for care at inappropriate rates. The results are provided to DHS' Office of Child Care and Family Services. Cases involving large overpayments or aggravated circumstances of fraud are referred for criminal prosecution to a state's attorney or a U.S. attorney.

Child Care Investigations
CY 2002

Investigations Completed	114
Overpayment Identified	$1,172,293

Client/Vendor Prosecutions

The OIG conducts investigations and refers cases of serious crimes involving large financial losses to a state's attorney or U.S. attorney for criminal prosecution. These cases may involve multiple cases with false identities, failure to report income, long term fraud involving the circumstances of the client and other instances that have resulted in large overpayments to undeserving individuals.

Client/Vendor Prosecutions
CY 2002

Prosecution	
Accepted for Prosecution	73
Overpayment on Cases	$955,398
Convictions	67
Restitutions Ordered	$537,966
Acquittals	1

Medical Abuse Investigations

The OIG investigates allegations of abuse of the Medical Assistance Program by clients. Abusive clients may be placed in the Recipient Restriction Program (RRP). The restriction process begins with a computer selection of clients whose medical services indicate abuse. After reviews by staff and medical consultants, clients are restricted to a primary care physician, pharmacy, or clinic for 12 months on the first offense and 24 months on a second offense. Services by other providers will not be reimbursed unless authorized by the primary care provider, except in emergencies. Abusive clients may choose to enroll in an HMO as an alternative to RRP.

Medical Abuse Investigations
CY 2002

Medical Overutilization	
12 Months	
Recipient Reviews Completed	4,373
Recipients Restricted for 12 months as of 01-01-02	765
Recipient Restrictions Added	627
*Recipient Restrictions Released	477
Recipients Restricted for 12 months as of 12-15-02	914
24 Months	
Recipient Re-evaluations Completed	467
Recipients Restricted for 24 months as of 01-01-02	226
Recipient Restrictions Added	26
*Recipient Restrictions Released	124
Recipients Restricted for 24 months as of 12-15-02	128
Recipients opt for an HMO vs. Restrictions as of 01-01-02	64
Recipients opt for an HMO vs. Restrictions as of 12-15-02	60

*Releases are a result of: cancellation of Medicaid eligibility, death of recipient, opting to select an HMO or program compliance.

HMO Marketer Investigations

The OIG monitors marketing practices to ensure clients have the opportunity to make an informed choice when enrolling with an HMO and to prevent HMOs from avoiding the sickest clients. The DPA's Bureau of Managed Care maintains a toll-free complaint hotline from which the majority of referrals are received. Marketers who have engaged in misconduct or fraudulent marketing practices are removed from the DPA's HMO Marketer Register, which lists HMO marketers from whom the DPA will accept enrollments.

HMO Marketer Investigations
CY 2002

Types of Allegations	
Fraud	9
Misrepresentation	3
Unethical Practices/Other	0
Total	12
Findings	
Substantiated	9
Unsubstantiated	0
Unable to Determine	3
Total	12

Internal Investigations

The OIG investigates allegations of employee and vendor misconduct and conducts threat assessments as part of its security oversight. The investigators are not sworn, do not carry firearms and do not have arrest powers. Investigations include criminal and non-criminal work-rule violations, public aid fraud, criminal code offenses and contract violations. Investigations often reveal violations of several work rules or criminal statutes. A single investigation may cite several employees or vendors. Resolutions may include resignation, dismissal, suspension or a reprimand.

Internal Investigations
CY 2002

Investigations Completed	
Substantiated	144
Unsubstantiated	49
Total	193
Types of Allegations	
Non-Criminal (Work Rules)	
Discourteous Treatment of Others	9%
Failing to Follow Instructions	4%
Negligence in Performing Duties	6%
Engaging in Business with a Client	0%
Incompatible Outside Interests	4%
Sexual Harassment	2%
Release of Confidential Agency Records	2%
Misuse of Computer System	6%
Falsification of Records	4%
Other Work Rule Violations	10%
Work Place Violence	14%
Criminal (Work Rules)	
Misappropriations of State Funds	1%
Attempted Fraud or Theft	3%
Commission of or Conviction of a Crime	2%
Other	0%
Public Assistance Fraud Offenses ILCS Chapter 305	1%
Criminal Code Offenses ILCS Chapter 720	27%
Contract Violations, Security Issues	2%
Special Projects, Background Checks, Assist other Agencies	3%
Total	100%
Misconduct Cited	
Employees	77
Vendors	10
Total	87

Resolutions	
Discharged	14
Resigned	18
Suspensions	26
Other, such as reprimands	26
Administrative Action Pending at Year End	9
No Action Taken	14
Total	107

APPENDIX - AGGREGATE PROVIDER BILLING/PAYMENT INFORMATION

Data showing billing and payment information by provider type and at various earning or payment levels can be accessed at www.state.il.us/agency/oig/docs/2002aggregate.pdf . The information, required by Public Act 88-554, is by provider type because the rates of payment vary considerably by type.

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